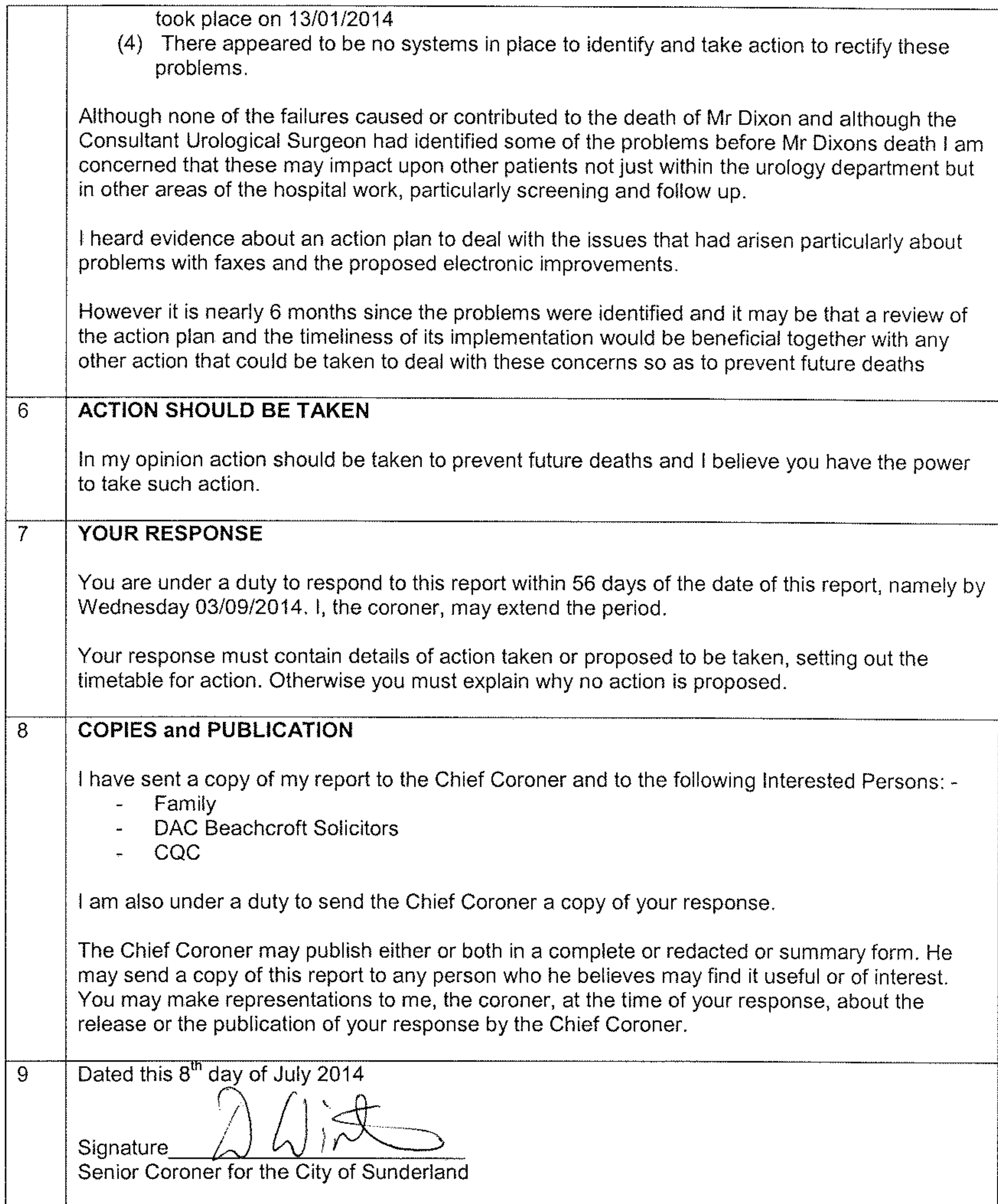
Derek Winter
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Ken W Bremner** **Chief Executive** **City Hospitals Sunderland NHS Foundation Trust** **Kayll Road** **Sunderland SR4 7TP**
1	**CORONER** I am Derek Winter, Senior Coroner for the City of Sunderland
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 01/04/2014 I commenced an investigation into the death of Thomas David Dixon, aged 62. The investigation concluded at the end of the Inquest on 03/07/2014. The conclusion of the Inquest was Natural Causes. Mr Dixon died from metastatic transitional cell carcinoma of the bladder.
4	**CIRCUMSTANCES OF THE DEATH** In May 2011 it was found that Mr Dixon had a bladder tumour shown to be invading the muscle of the bladder and also a carcinoma in situ. He was not fit enough to undergo surgery but did have radiotherapy. In August 2012 it was noted that he had no obvious tumour and a further check was to be made in 6 months time. Mr Dixon was next seen on 14/08/2013. The evidence at the Inquest was that he ought to have had an urgent procedure within 4-6 weeks. That procedure did not take place until 13/01/2014. The referral form for the procedure could not be found. Surgery and further radiotherapy were not options for Mr Dixon who died at St Benedict's Hospice on 29/03/2014.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. - (1) There was a failure to give Mr Dixon an appointment 6 months after he was seen in August 2012 (2) There was a failure to give Mr Dixon an urgent appointment for a procedure within 4-6 weeks of the 14/08/2013 (3) Important documentation was missing namely the referral form for the procedure that



	took place on 13/01/2014 (4) There appeared to be no systems in place to identify and take action to rectify these problems. Although none of the failures caused or contributed to the death of Mr Dixon and although the Consultant Urological Surgeon had identified some of the problems before Mr Dixons death I am concerned that these may impact upon other patients not just within the urology department but in other areas of the hospital work, particularly screening and follow up. I heard evidence about an action plan to deal with the issues that had arisen particularly about problems with faxes and the proposed electronic improvements. However it is nearly 6 months since the problems were identified and it may be that a review of the action plan and the timeliness of its implementation would be beneficial together with any other action that could be taken to deal with these concerns so as to prevent future deaths
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 03/09/2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - - Family - DAC Beachcroft Solicitors - CQC I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated this 8th day of July 2014 Signature________ Senior Coroner for the City of Sunderland